COMMUNITY ASSESSMENT 1: BASIC CONCEPTS

October 8, 2003
Sacramento, CA

Jointly sponsored by
California Department of Health Services, Maternal and Child Health Branch,
Perinatal Advisory Council: Leadership, Advocacy, and Consultation (PAC/LAC),
and Family Health Outcomes Project, UCSF
COMMUNITY ASSESSMENT 1: BASIC CONCEPTS

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By the end of the training, participants should be able to perform and facilitate a community health assessment with other staff for their next scope of work. At the conclusion of this course, the participant will be able to:

- Articulate the steps of a community assessment process
- Develop a community health profile
- Assess the adequacy of MCH community resources
- Assess MCH agency capacity
- Measure and assess required Title V indicators
- Identify the advantages and disadvantages of qualitative and quantitative data

8:30 am Coffee and Registration

9:00 am Welcome, Introductions, and Overview of Title V Planning Model
   Introduction to Planning Cycle
   Geraldine Oliva, MD, MPH and Judith A. Hager Belfiori, MA, MPH

9:45 am Session 1. Community Health Profile
   Nadia Thind, MPH

10:15 am Break

10:25 am Session 1. Community Resources Assessment
   Nadia Thind, MPH

10:40 am Session 2. Assessment of MCH Capacity
   Judith A. Hager Belfiori, MA, MPH

11:20 am Session 3. Measuring and Assessing Required Title V Indicators
   Brianna Gass, MPH and Judith A. Hager Belfiori, MA, MPH

12:00 pm Lunch

1:00 pm Exercise.

2:15 pm Break

2:30 pm Session 4. Options for Collecting and Presenting Community Assessment Data
   Geraldine Oliva, MD, MPH

3:45 pm Review of State MCH Timeline and Preview of Next Workshop
   Wrap Up and Evaluation
   Geraldine Oliva, MD, MPH
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COMMUNITY ASSESSMENT 1: BASIC CONCEPTS

Overview

Developing an Effective MCH Planning Process

Presented by:

Geraldine Oliva, MD, MPH
Director
Family Health Outcomes Project

Judith A. Hager Belfiori, MA, MPH
Director of Planning and Evaluation
Family Health Outcomes Project
Developing an Effective MCH Planning Process, Community Assessment 1: Basic Concepts

Gerry Oliva, M.D, MPH
Family Health Outcomes Project
October 8, 2003

Historical Context

- 1989 - OBRA ‘89 requires the federal MCH Bureau to monitor a set of HP 2000 indicators
- 1992 - AB99 Committee in California recommends monitoring a larger number of HP2000 indicators
- 1993 - California MCH Branch with FHOP initiates data capacity building effort to assist local health jurisdictions (LHJs)

Historical Context (cont)

- 1993 - Government Performance and Results Act (GPRA) mandates performance measures
- 1997 - Federal MCHB Title V grant guidance requires state reporting on performance indicators and outcomes
- 1998 - CAMCHB requires LHJs to include these measures in their 5-year assessments
- 1999 Federal MCHB adds needs indicators to the Title V Guidance
2003 and Beyond

- 2003 Federal MCHB 2005 grant guidance includes more indicators

Components of the 2003 CAMCH Guidelines

- Description of the Community Assessment Process
- MCH Planning Group Mission Statement and Goals
- Community Assessment
- Priority Identification
- Formal Problem Analysis for at least one priority problem

Components of the Community Assessment

- Community health profile
- Community resource assessment
- MCH agency capacity assessment
- Analysis of data on state required Title V indicators and other LHJ selected indicators
- Identification of problems/assets/unmet needs
Resources for the Community Assessment Process

- FHOP and MCH Epi identifying or developing most of the data that local programs will need
- FHOP posting data or data links as they are prepared/identified on web site
- FHOP to send e-newsletter or data alert for new or updated data

REMEMBER the PROGRAM PLANNING CYCLE

Convene Community Coalition

Assess Community Needs, Assets and Resources

Prioritize Health Problems

Analyze Problems / Develop Objectives and Performance Measures

Implement Program/Plan Evaluation

Develop Interventions

Evaluate Program

Today’s Training Objectives

1. Articulate the steps of a community assessment process
2. Develop a community health profile
3. Assess the adequacy of community MCH related resources
Training Objectives (cont)

4. Assess MCH agency capacity
5. Measure and assess required Title V indicators
6. Identify the advantages and disadvantages of qualitative and quantitative data

Today’s Agenda

- Review of state MCH requirements for 2004 community assessment
- Developing a Community Health Profile
- Conducting a Community Resource Assessment
- Assessing MCH Agency Capacity
- Assessing Required MCH and County Selected Indicators
- Options for Collecting and Presenting Indicator Data
COMMUNITY ASSESSMENT 1:
BASIC CONCEPTS

Session One

Community Health Profile and
Community Capacity Assessment

Presented by:

Nadia Thind, MPH
Research Associate
Family Health Outcomes Project
LEARNING OBJECTIVES:

By the end of the presentation and session, participants will be able to name the components of a community health assessment and:

1. Develop a community health profile
2. Assess the adequacy of MCH community resources

REFERENCES FOR THIS SESSION


SESSION

This session consists of a lecture/slide show presentation. The presentation will include an interactive discussion of the process of developing and finding data for a community health profile. Participants will be asked to discuss how they will develop their community health profile in their programs, using several websites for the profile.
Community Health Profile and Community Resources Assessment

Nadia Thind, MPH
Family Health Outcomes Project
October 8, 2003

Session Objectives

- By the end of this session, participants will be able to:
  - Develop a community health profile
  - Select appropriate resources for a community health profile

What Does a Community Health Assessment Tell Us?

- Overall health status of the population
- Population’s health problems/ needs
- Population(s) at highest risk for health problems
- Community’s strengths or assets
- Resources that are available in the community
Community Health Assessment Components

1. Develop a community health profile
2. Assess capacity to address health issues
3. Assess required MCH Indicators / other locally relevant MCH Indicators
4. Collect, analyze, and present the data
5. Identify problems and set priorities

Community Health Profile

- A description of the overall community
- Gives the reader a picture of the quality of life in the community
- In order to describe the health of a community, public health indicators must be used

Public Health Indicators

Definition:
Precisely defined, standardized, quantifiable measures of a population’s health risks, health status, or health service utilization
Use of Public Health Indicators

- Public health agencies use indicators to:
  - Describe the population’s demographic characteristics
  - Describe the health status of the population
  - Identify unmet health needs
  - Describe the health delivery system in a community
  - Identify areas of service deficiency

A Community Health Profile Contains:

- Description of geographic features of the health jurisdiction
- Summary of relevant data including population, family structures, educational status, income and employment status
- Communicable disease rates
- Description of economic factors

A Community Health Profile Contains:

- Highlights from vital records including fertility and birth rates, death rates and causes of death
- Availability of affordable housing and jobs
- Major health issues - food safety, bioterrorism, environmental factors
- Immigration trends
Community Assets Assessment

- Some community characteristics and resources are associated with greater well-being of residents and include:
  - Number of libraries
  - Playgrounds
  - Health care facilities
  - Schools with after-school programs

Readily Available Data for a Community Health Profile

- See Appendix II-B of the Planning Guide (in your binder)
- FHOP Website: http://www.ucsf.edu/fhop

Readily Available Data for a Community Health Profile

- Geographic features: http://www.wikipedia.org/wiki/List_of_California_counties or County website
- U.S. Census site: http://quickfacts.census.gov/qfd/states/06000.html
Readily Available Data for a Community Health Profile

- Communicable Disease Rates- [link](http://www.dhs.ca.gov/ps/dcddc/STD/stddata summaries.htm) and [link](http://www.dhs.ca.gov/ps/dcddc/STD/areport s.htm)
- Affordable Housing and Employment- [link](http://www.calmis.ca.gov/htmlfile/subject/lift able.htm)

Readedly Available Data for a Community Health Profile

- Trends in School Enrollment- [link](http://data1.cde.ca.gov/dataquest/)
- Economic Factors- [link](http://www.dof.ca.gov/HTML/FS_DATA/profile s/pf_home.htm)
- Other Major Health Issues- [link](http://www.dhs.cahwnet.gov/ps/ddwem/environmental/epo/EPOBioterrorism.html) and [link](http://www.pepps.fsu.edu/epic/)

Readedly Available Data for a Community Health Profile

- Political Issues- refer to your county’s website
- Immigration Trends- [link](http://www.dof.ca.gov/HTML/DEMOGRAP/repn dat.htm#immigration) and [link](http://eire.census.gov/popest/data/counties.ph p)
- Health Systems- [link](http://www.chis.ucla.edu/) and [link](http://www.healthpolicy.ucla.edu/pubs/publicat ion.asp?pubID=34)
Mini-Exercise

Developing a Community Profile and Finding the Appropriate Resources

Capacity to Address Health Issues
Community Resources Assessment

- Every profile should contain information on the capacity of its health care and social services system to meet the needs of its population
- Identify and describe both strengths and gaps in services (access to healthcare, cultural acceptability, availability of specialty care providers)

Organize the information into tables, charts or maps
http://www.oshpd.cahealth.gov/HQAD/HIRC/Perspectives/Standard_Pages/county_icons1.htm

- Networks, coalitions, and collaboratives that impact the MCH population should also be described
Family Health Outcomes Project Overview

- Provides website links for various indicator data, including:
  - Population and SES
  - Economics
  - Health Services
  - Education
  - www.ucsf.edu/fhop
Help is Here!!!
www.ucsf.edu/fhop

- Trainings
- Technical Assistance
- Planning Guide
- Automated Tools- EpiBC, EpiInfo, EpiHOSP, Data Templates (perinatal, domestic violence, injuries, maternal/infant screening)
## COMMUNITY HEALTH PROFILE SOURCES

<table>
<thead>
<tr>
<th>Source</th>
<th>What's There?</th>
</tr>
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<td><strong>Geographic/ Demographic Features</strong></td>
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<tr>
<td>County website</td>
<td>Geographic description</td>
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<tr>
<td><strong>Vital Records</strong></td>
<td></td>
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<tr>
<td><strong>Communicable Diseases</strong></td>
<td></td>
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</tr>
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<td><a href="http://www.calmis.ca.gov/htmlfile/subject/lftable.htm">http://www.calmis.ca.gov/htmlfile/subject/lftable.htm</a></td>
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<td><a href="http://data1.cde.ca.gov/dataquest/">http://data1.cde.ca.gov/dataquest/</a></td>
<td>Enrollment trends, Graduation, test results</td>
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<td><strong>Economic Factors</strong></td>
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<td><strong>Other Major Health Issues</strong></td>
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<tr>
<td><a href="http://www.pepps.fsu.edu/epic/">http://www.pepps.fsu.edu/epic/</a></td>
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<td><strong>Political Issues</strong></td>
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<td>Updates on local political issues</td>
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<td><strong>Immigration Trends</strong></td>
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<td><a href="http://www.dof.ca.gov/HTML/DEMOGRAP/repndat.htm#immigration">http://www.dof.ca.gov/HTML/DEMOGRAP/repndat.htm#immigration</a></td>
<td>Legal immigration</td>
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<tr>
<td><strong>Health Systems</strong></td>
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<tr>
<td><a href="http://www.chis.ucla.edu/">http://www.chis.ucla.edu/</a> <em>Need to register</em></td>
<td>Health insurance info, access and utilization, public program participation</td>
</tr>
</tbody>
</table>
A. Alameda County Profile

A.1 Geographic Features: Alameda County is located on the eastern side of San Francisco Bay extending from the urban northern region of the county, Berkeley and Albany, south to Fremont and then east to the more sparsely populated communities in the Livermore valley. The county encompasses a land area of 737.5 square miles, bounded on the north by Contra Costa County, on the south by Santa Clara County, on the southeast by Stanislaus County, on the east by San Joaquin County and on the west by the San Francisco Bay. The county has a varied geography, with wooded hills, vineyards, streams, and lakes. Elevations in Alameda County range from sea level to 3,817 ft. at Rose Peak in the southern part of the county. It is a highly industrialized county; an overwhelming majority (98%) of Alameda County residents live in urban or suburban areas, with only 2% residing in rural areas.

A.2 Population Demographics\[1\]: With an estimated population of 1,349,500, Alameda County is the seventh most populous county in California, and is honored to be one of the most ethnically diverse regions in the country. From 1990 to 1998, Alameda County has grown by 5.2%. The proportion of families has grown by 3.3%, about half the growth rate of California, 7.6%. In 1998, Alameda County’s population is evenly divided by gender, with 50.7% females and 49.3% males. More than half of the population is comprised of minority groups, with approximately one fifth each of Asians, Hispanics and African Americans. In terms of marital status, 48.9% of the residents are married, 31.8% have never been married, and 18.9% are divorced, separated or widowed.

Table 1: Alameda County Population Demographics – 1998

<table>
<thead>
<tr>
<th>Age (years)</th>
<th>Race/Ethnicity</th>
<th>Gender</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>No. (%)</td>
<td>No. (%)</td>
</tr>
<tr>
<td>0-4</td>
<td>95516 (6.53%)</td>
<td>White 46.60%</td>
</tr>
<tr>
<td>5-14</td>
<td>190449 (13.0%)</td>
<td>African-American 17.00%</td>
</tr>
<tr>
<td>10-14</td>
<td>115082 (7.87%)</td>
<td>Hispanic 17.90%</td>
</tr>
<tr>
<td>15-24</td>
<td>161919 (11.06%)</td>
<td>Asian 17.90%</td>
</tr>
<tr>
<td>25-34</td>
<td>215890 (14.76%)</td>
<td>American-Indian 0.40%</td>
</tr>
<tr>
<td>35-44</td>
<td>246253 (16.84%)</td>
<td>Other 0.30%</td>
</tr>
<tr>
<td>45-54</td>
<td>178257 (12.19%)</td>
<td></td>
</tr>
<tr>
<td>55-64</td>
<td>107107 (7.32%)</td>
<td></td>
</tr>
<tr>
<td>65-74</td>
<td>80538 (5.51%)</td>
<td></td>
</tr>
<tr>
<td>75-84</td>
<td>51257 (3.50%)</td>
<td></td>
</tr>
<tr>
<td>85+</td>
<td>20439 (1.40%)</td>
<td></td>
</tr>
</tbody>
</table>

The proportion of women of childbearing age (15 to 44 years) of the total population in the county is 23.5% in 1998. Alameda County has the seventh largest population of children in the State, with 25% of county residents under the age of 18 years. In 1990, the median age of Alameda County residents

\[1\] 1990 Census, Department of Finance; 1998 Claritas
was 32.7 years. Children less than 5 years old account for 7.5% of the population, and young people between 6 and 20 years of age were 26.5%. From 1990 to 1998, considerable growth has been observed in elementary (15.2%) and middle school (20.3%) children, and among adults in their forties and fifties (30%).

The proportion of people living in poverty decreased slightly in Alameda County between 1993 to 1995 from 12.3% to 11.3%, and the proportion of children under 18 years living in poverty decreased from 18.5% to 17.3%.

A.3 Social-Economic Status: Alameda County has a bimodal income distribution – a large number of poor people, and a large number of wealthy people. Using 1998 Claritas, it is estimated that about half of the county’s households earn less than $50,000 a year and approximately half earn more. The 1990 Census reports that average annual income per person for residents of the county were $17,546. The median income of the county residents was $45,037.

The unemployment rate for Alameda County has remained below that for California as a whole for the entire decade, decreasing steadily from 6.6% in 1993 to 4.1% in 1998. The most recent figures for Alameda County show an unemployment rate for February 1999 of 3.8%.

A.4 Education Status: Alameda County residents have higher levels of education than do other Californians. 81% of the county’s population aged 25 and over has graduated from high school. In 1996-97, the overall graduation rate from Alameda County public schools was 66.0%. Although high school dropout rates for the county are declining for all race/ethnic groups, they vary considerably by school districts. For students in grades 9-12 during the 1993-94 school year, Oakland School District had the highest dropout rate (8.0%), followed by Hayward (5.7%). The overall dropout rate for Alameda County was 3.9%.

A.5 Migration Trends: From 1990 to 1992, there were more people moving into the county than leaving, but from 1993 to 1995, there were more people leaving, and since 1996 there has been a net

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2 California Employment Development Department Website
4 California Department of Finance, Demographic Research Unit
increase in the number of people moving into the county. During the period between 1990 to 1996, four to seven thousand Whites migrated out of the county annually. In contrast, thousands of various ethnic populations (especially Asians/Pacific Islanders) migrated into the county each year, and contributed to the increase in the county’s population.

A.6 Racial/Ethnic Composition and Shift:

**Racial/Ethnic Composition:** Alameda County is honored to be one of the most ethnically diverse regions in the country, with at least 81 different languages spoken in the communities. The richness and uniqueness of ethnic diversity and immigrant culture are valuable assets for the community. They also pose a challenge for Public Health professionals as they seek to develop a variety of strategies necessary to provide services that are culturally and linguistically competent.

**Racial/Ethnic Population Shift:** The county continues to be a magnet for immigrants. Alameda County has experienced significant demographic shifts in the last decade. In 1998, 46.6% of Alameda County was Whites, decreasing from 61.6% in 1980; 17% African American, compared to 18.2% in 1980; 18.6% Asian/Other, increasing significantly from 7.6% in 1980, and 17.9% Hispanic, compared to 11.7% in 1980. There were notable differences in rates of growth of the population by race/ethnicity. The Asian population has been the fastest growing segment of the population (32.6% increase since 1990), followed by Hispanics (30.2% increase since 1990). The African American population has stayed relatively stable in the 1990s, while the proportion of the White population has decreased by 24%.

**A.7 Vital Statistics:** The total number of births has been steadily declining in the county since 1990. In 1996, the crude birth rate was 15.1 per 1,000 people and the general fertility rate was 66.3 births per 1,000 women of childbearing age. In 1997, Alameda County recorded 20,761 live births, with Medi-Cal paying for 32.1% of these deliveries. The crude death rate was 7.1 per 1,000 people. There were 6 infant deaths (under 1 year of age) per 1,000 live births, 3.5 per 1,000 births in the neonatal period (less than 28 days) and 2.6 per 1,000 in the post-neonatal period (28 days up to 1 year). There were 6.1 fetal deaths per 1,000 live births plus fetal deaths. (See table 2)
### Table 2: Population Distribution, Birth Distribution, Crude Birth rate and General Fertility Rate by Race/ Ethnicity, California and Alameda County, 1996

<table>
<thead>
<tr>
<th>Race/Ethnicity</th>
<th>Alameda Population</th>
<th>California Births</th>
<th>Alameda Births</th>
<th>Crude Birth Rate per 1000 population</th>
<th>General Fertility Rate per 1000 women aged 15-45</th>
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</thead>
<tbody>
<tr>
<td></td>
<td>No.</td>
<td>%</td>
<td>No.</td>
<td>%</td>
<td>No.</td>
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<tr>
<td>Non-Hispanic White</td>
<td>654,915</td>
<td>47.98</td>
<td>185,441</td>
<td>34.38</td>
<td>7,038</td>
</tr>
<tr>
<td>Hispanic White</td>
<td>21,7719</td>
<td>15.95</td>
<td>253,875</td>
<td>47.07</td>
<td>5,221</td>
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<tr>
<td>African-American</td>
<td>24,1363</td>
<td>17.68</td>
<td>38,001</td>
<td>7.05</td>
<td>3,715</td>
</tr>
<tr>
<td>American Indian</td>
<td>6,683</td>
<td>0.49</td>
<td>2,694</td>
<td>0.50</td>
<td>96</td>
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<tr>
<td>South East Asian</td>
<td>26,024</td>
<td>1.91</td>
<td>10,596</td>
<td>1.96</td>
<td>593</td>
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<tr>
<td>Other Asian</td>
<td>141,051</td>
<td>10.33</td>
<td>24,265</td>
<td>4.50</td>
<td>1,799</td>
</tr>
<tr>
<td>All other</td>
<td>77,286</td>
<td>5.66</td>
<td>22,667</td>
<td>4.20</td>
<td>1,984</td>
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<td>1,365,041</td>
<td>100.00</td>
<td>539,360</td>
<td>100.00</td>
<td>20,682</td>
</tr>
</tbody>
</table>

Source: Maternal and Infant Health Profile for Alameda County, University of California Berkeley

http://datamch.berkeley.edu/ipodm/cprs1997/poo1.htm
Working off the previous 5-year plan and the suggestions FHOP has made to update the profile and assessment, FHOP has created summary statements for a community health profile and community resources assessment. Please refer to Alameda County’s 1999 Community Health and Health Services Systems included earlier in this binder. The supporting data, graphics and/or maps should have been included in the profile and community resources assessment, in the future.

Community Health Profile Summary

The following are the major findings from the Community Health Profile for Alameda County, and need to be considered when identifying and responding to health problems.

- Alameda County is the seventh most populous county in California and growing, although at a rate lower than the State. It is a highly industrialized county with 98% of the population living in urban or suburban areas.
- Has the largest population of children in the state with 25% of residents under the age of 18 years.
- Is ethnically diverse, with at least 81 different languages spoken in the communities.
- Over the past decade, there has been a significant demographic shift from 62% white in 1980 to 47% white in 1998, 17% African American compared to 18.6% in 1980. The growth in population has occurred amongst Hispanics who constitute 18% of the population (30.2% increase since 1990) and the Asian population (32.65 increase since 1990).
- The population is economically diverse with a large number of poor people and a large number of wealthy people. In 1997, approximately 1/3 of the 20,761 live birth deliveries in the county were paid for by Medi-Cal.
- County residents have a higher level of education than do other Californians, 81% of the county’s population, aged 25 and over has graduated from high school.
- The county has implemented the “Mobilization for Action through Planning and Partnership (MAPP)” planning process, which shows the county has strong assets in community organizing capacity, churches, etc. (added as an example of how the significant findings from an Assets Assessment might be included)
- The total number of births has been steadily declining in the county since 1990. In 1996, the crude birth rate was 15.1 per 1,000 people and the general fertility rate was 66.3 births per 1,000 women of childbearing age.

Community Resources Assessment Summary

The following are the major findings from the Community Resources Assessment for 1999:

- Alameda County has 13 not-for-profit and for-profit hospitals. The major sources of OB delivery for low-income women are Summit and Highland Hospitals in Oakland and Alta Bates Hospital in Berkeley where the highest concentration of low-income individuals live (as shown on Map ___).
• It has 2 Medi-Cal managed care plans: the county-operated Alameda Alliance for Health and the Private Blue Cross Medi-Cal managed Care plan. Providers of care to low income women are providers in both plans. (Map ___ shows the concentration of providers who 1) accept Medi-Cal or 2) are Healthy Families providers or 3) have sliding scale services to be located in the ______________ neighborhoods. (hypothetical) (If Alameda County had included information in their profile about where the providers are located, in relation to need of the population, they should have drawn some conclusions about the accessibility of providers)

• There are 394 persons per physician. In addition, there are 1,153 persons per dentist. In California, there are 400 persons per physician and 1,257 persons per dentist. This shows that Alameda County is providing has about the same ratio of providers to population as the State.(See Health Data Summaries for California Counties 2002)

• The county has implemented the “MAPP” planning process, which shows gaps in services in the following areas: (hypothetical)
  o Staff that speak the appropriate languages for the population served
  o Lack of choice of providers for patients
  o Lack of transportation services is a problem for respondents in all towns, but especially for those living in the rural towns.
COMMUNITY ASSESSMENT 1: BASIC CONCEPTS

Session Two

MCH Program Capacity Assessment

Presented by:

Judith A. Hager Belfiori, MA, MPH
Director of Planning and Evaluation
Family Health Outcomes Project
LEARNING OBJECTIVES

By the end of the presentation and session, participants will be able to describe how to conduct an MCH capacity assessment including:

1. Define MCH capacity
2. Describe the purpose of the assessment
3. Describe how to use an assessment tool to assess MCH capacities
4. Describe possible MCH capacity assessment processes
5. List what should be included in the “Assessment of MCH Capacity” section of the Title V 5 year MCH Needs Assessment Report

REFERENCES FOR THIS SESSION

2. California MCH Five Year Needs Assessment Guidelines & Indicator List for MCAH Jurisdictions, August 2003

SESSION

This session consists of a lecture/slide show presentation titled “MCH Program Capacity Assessment.” The presentation will include an interactive discussion of the process for assessing capacities and the use of a rating tool. Participants will be asked to discuss how they might conduct this assessment in their programs.
MCH Program Capacity Assessment

Judith A. Hager Belfiori, MA, MPH
Family Health Outcomes Project
October 8, 2003

Objectives for this Session

Participants will be able to conduct and report on an assessment of their local MCH Program capacity:

- Purpose
- Review capacities / core functions
- Tools
- Process
- Report

MCH Capacity

Ability to Carry Out its Functions to Promote and Protect the Health of Mothers and Children
Purpose of Capacity Assessment

- Self-examination (Program)
- Assist prioritization of problems to be addressed
- Inform planning groups of capacity / resources
- Develop future strategies
- Information for State's assessment

State’s Interests

- Coordination on the local level
- Emerging issues
- Ongoing issues

Who Performs the Assessment?

- Internal to MCH (representative staff / key partners)
Where Does it Fit into the Title V 5 Year Assessment Process?

- Community Selected Indicator Assessment
- Health Status Profile
- Problem Identification, Prioritization, Analysis
- Required Indicator Assessment
- Community Resource Assessment
- MCH Capacity Assessment

Part I. Assessment of MCH Capacity

- Organizational relationships
  - Within public health
  - Within MCH
- Resources (funds, staff, other)
- Cultural competency
- Core functions

Core MCH Program Functions

For the MCH population: (Refer to handout)

- Monitor health status
- Diagnose & Investigate community problems
- Inform, Educate, Empower people
- Mobilize community partnerships
Core Functions (more)

- Develop policies and plans
- Link people to services
- Evaluate effectiveness, access and quality of pop-based services
- Research for insights / solutions

Part II of the Assessment:

- Issues in public and private health care which are affecting the role / capacity of MCH (emerging, ongoing)
- Local collaborations (convened by MCH / in which MCH participates)
- (If applies) Participation in / Impact of any research efforts

Capacity Assessment Tools

- Recommended tool
- Existing assessments
Let's see how it works

Relax, it's easy

MCH Capacity Rating and Reporting Tool

Part I: Capacity Assessment

<table>
<thead>
<tr>
<th>Assessment</th>
<th>Strong</th>
<th>Moderate</th>
<th>Weak</th>
<th>Circle</th>
</tr>
</thead>
<tbody>
<tr>
<td>Organizational relationships</td>
<td>4</td>
<td>3</td>
<td>2</td>
<td>1</td>
</tr>
<tr>
<td>Cultural competency</td>
<td>4</td>
<td>3</td>
<td>2</td>
<td>1</td>
</tr>
</tbody>
</table>

Summary of Challenges
1. 
2. 
Summary of Opportunities
1. 
2.

Part II: Capacity Assessment

List emerging issues affecting MCH

How MCH responded / its role / challenges

List ongoing issues affecting MCH

How MCH responded / its role / challenges

List Collaboratives / Networks convened by MCH

Membership

List Collaboratives / Networks in which MCH participates

Summarize membership
**Assessment Process**

- Decide who should participate
- Discuss and introduce purpose / framework
- Assess capacities -- use worksheet or other method
- Complete capacity assessment rating & reporting tool
- Summarize for report / planning group
- Compare to needs / (later)

---

**What belongs in the report?**

- Summary of assessment process / methods (1 ¶)
- Summary of conclusions about MCH capacity (concise, include assessment tool, MCH and Department organization charts)
- a) A list of issues in public and private health care affecting MCH (+ into emerging / ongoing) and
  b) A summary of impact on MCH and its response

---

**What belongs in the report?**

- a) A list of collaboratives, networks in which MCH plays a role (+ into those convened by MCH and those in which MCH participates),
  b) membership
- (If applies) A brief summary of any research activities MCH has been involved in and how the findings have been used
ASSESSING LOCAL MCH PROGRAM CAPACITIES
TITLE V FIVE YEAR NEEDS ASSESSMENT
Supplement to the MCH Capacity Rating and Reporting Tool
and the Assessment Worksheets

Part I. Capacity Assessment. Assess and rate MCH program capacity on a scale of 4 to 1 (strong capacity to weak capacity) and identify opportunities and challenges in each of the following areas.

A. Organizational Relationships
Consider
- MCH participation in the leadership and overall strategic planning of the public health department
- relative authority / organizational influence within the department

B. Adequacy of Cultural Competency
Consider capacity to
- assess cultural needs
- respond (within MCH and amongst partners / coalitions) to identified needs

C. Adequacy of MCH Resources
Consider
- allocated program funding
- ability to generate grants and other funding
- adequacy of staffing and appropriate education / training of staff in relation to responsibilities

D/E Other MCH Capacities (Optional)

Core Function #1: Monitor Health Status to Identify MCH Health Problems
Consider capacity to
- accurately, periodically select and review indicators to assess community / maternal and child health status including adequacy of MIS and data collection capabilities
- utilize appropriate methods and technology, such as indicator data, geographic mapping, etc.
- collaborate with private providers, health plans, other departments to collect data

Core Function #2: Diagnose and Investigate MCH Health Problems in the Community
Consider capacity to
- analyze data – have expertise and understanding of how to manipulate the data to answer questions about it
- access expertise in epidemiology to investigate and look for causes and solutions
- respond to emerging problems
- coordinate with other county health and social service agencies and community based agencies to diagnose and investigate these problems
ASSESSING LOCAL MCH PROGRAM CAPACITIES
TITLE V FIVE YEAR NEEDS ASSESSMENT

Core Function #3: Inform, Educate and Empower People about MCH Health Issues
Consider capacity to develop and implement:
- health Information, health education and health promotion activities designed to reduce health risk and promote better health
- health communication plans and activities appropriate to your communities, e.g., media advocacy, social marketing, community health workers
- accessible health information and education resources
- health education and promotion program partnerships with schools, faith communities, worksites, etc, to reinforce MCH health promotion programs and messages

Core Function #4: Mobilize Community Partnerships to Identify and Solve MCH Problems
Consider capacity to
- identify and involve potential stakeholders
- build networks, coalitions and collaborations to address MCH issues
- convene, coordinate and facilitate partnerships among groups and associations to undertake defined MCH programs / activities

Core Function #5: Develop Policies and Plans that Support Individual and Community Health Efforts
Consider capacity to
- develop and implement internal Departmental policies affecting the health/health care of women and children
- work with other agencies, CBOs, service providers, advocacy groups and others to develop plans and improve policies which affect health status and access to and quality of health services for women and children
- access and inform/educate local and state policy makers

Core Function #6: Link Women and Children to Needed Health Services and Assure the Provision of Health Care to the MCH population when Otherwise Unavailable
Consider capacity to
- identify barriers to women’s and children’s health services and work with the public and private sectors to develop interventions to address barriers, e.g., culturally and linguistically appropriate staff and materials, transportation services, etc.
- connect women and children to health care including outreach, advocacy and linking to services, providing case management, linking to a source of insurance, etc.
- provide direct MCH health care services as needed in your county; e.g., family planning, school based services, immunizations, etc.
Core Function #7: Evaluate Effectiveness, Accessibility, and Quality of Personal and Population–Based Health Services
Consider capacity to:
- conduct evaluation of MCH programs at the basic level of monitoring program process measures and monitoring program outcomes
- assist health care providers and plans to evaluate their MCH related services and programs

Core Function #8: Research for New Insights and Innovative Solutions to Health Problems
Consider capacity to
- link to Universities, access researchers with knowledge and skill to design and conduct health-related studies
- participate in research projects such as those funded by CDC, HRSA, which contribute to health policy and improved health services, etc.

Part II. Capacity Assessment. Provide summary information for the following:

Emerging issues/policies in the public or private health care sectors (or related sectors) that impact the local MCH program. List the emerging significant issues that impact or are anticipated to impact the role of the local MCH program in the community, its functions and/or its capacity to perform its functions. Briefly indicate in what ways the issue(s) are being addressed by MCH.

Ongoing issues/policies in the public or private health care sectors (or related sectors) that impact the local MCH program. List the ongoing issues that affect MCH program capacity to perform its roles and functions. Briefly indicate in what ways the issue(s) are being addressed by MCH.

Collaboratives/ Networks/ Partnerships. List the collaboratives, networks and partnerships that have 1) been convened by MCH and 2) in which MCH participates. If the focus of the collaborative or network is not obvious by its title, provide the focus. For the major MCH convened planning group(s) provide a full description of membership or include in an appendix. For others, summarize membership categories, e.g., child advocates, social services representatives, health plan representative, etc.

(If Applies) Research activities and results. If your program is conducting or has conducted any MCH population research or health care service delivery research, briefly describe the area of research, any results and how the findings have been used by MCH or others to increase capacity or improve services.
## Part I. Capacity Assessment

Assess MCH capacity in each of the areas below:

<table>
<thead>
<tr>
<th>Area</th>
<th>Strong</th>
<th>Adequate</th>
<th>Inadequate</th>
<th>Weak</th>
</tr>
</thead>
<tbody>
<tr>
<td>A. Organizational relationship within Health Department</td>
<td>4</td>
<td>3</td>
<td></td>
<td>1</td>
</tr>
<tr>
<td>B. Cultural competency</td>
<td>4</td>
<td>3</td>
<td></td>
<td>1</td>
</tr>
<tr>
<td>C. Resources</td>
<td>4</td>
<td>3</td>
<td></td>
<td>1</td>
</tr>
<tr>
<td>D. Coordination/Collaboration with other Agencies/CBOs</td>
<td>4</td>
<td>3</td>
<td></td>
<td>1</td>
</tr>
<tr>
<td>E. Other</td>
<td>4</td>
<td>3</td>
<td></td>
<td>1</td>
</tr>
</tbody>
</table>

Rate capacity in each area by checking a number:
4 = strong, 3 = adequate, 2 = inadequate, 1 = weak

Strong ▶ Weak

Summary of Opportunities

Summary of Challenges
## MCH Capacity Rating and Reporting Tool

<table>
<thead>
<tr>
<th>Core Public Health/ MCH Functions</th>
<th>Rate capacity in each area by checking a number: 4 = strong, 3 = adequate 2 = inadequate, 1= weak</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>1. Monitor health status</strong></td>
<td>Strong: 4</td>
</tr>
<tr>
<td>Summary of Opportunities</td>
<td>4</td>
</tr>
<tr>
<td>Summary of Challenges</td>
<td></td>
</tr>
<tr>
<td><strong>2. Diagnosis &amp; investigate community problems</strong></td>
<td>Strong: 4</td>
</tr>
<tr>
<td>Summary of Opportunities</td>
<td>4</td>
</tr>
<tr>
<td>Summary of Challenges</td>
<td></td>
</tr>
<tr>
<td><strong>3. Inform, educate, empower people</strong></td>
<td>Strong: 4</td>
</tr>
<tr>
<td>Summary of Opportunities</td>
<td>4</td>
</tr>
<tr>
<td>Summary of Challenges</td>
<td></td>
</tr>
<tr>
<td><strong>4. Mobilize community partnerships</strong></td>
<td>Strong: 4</td>
</tr>
<tr>
<td>Summary of Opportunities</td>
<td>4</td>
</tr>
<tr>
<td>Summary of Challenges</td>
<td></td>
</tr>
<tr>
<td><strong>5. Develop policies and plans</strong></td>
<td>Strong: 4</td>
</tr>
<tr>
<td>Summary of Opportunities</td>
<td>4</td>
</tr>
<tr>
<td>Summary of Challenges</td>
<td></td>
</tr>
</tbody>
</table>
### MCH Capacity Rating and Reporting Tool

#### 6. Link women and children to services

<table>
<thead>
<tr>
<th>Summary of Opportunities</th>
<th>4</th>
<th>3</th>
<th>2</th>
<th>1</th>
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<tbody>
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</table>

<table>
<thead>
<tr>
<th>Summary of Challenges</th>
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<th>3</th>
<th>2</th>
<th>1</th>
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</thead>
<tbody>
<tr>
<td><em>summary_text</em></td>
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</table>

#### 7. Evaluate effectiveness, access and quality of population based services

<table>
<thead>
<tr>
<th>Summary of Opportunities</th>
<th>4</th>
<th>3</th>
<th>2</th>
<th>1</th>
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</thead>
<tbody>
<tr>
<td><em>summary_text</em></td>
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<table>
<thead>
<tr>
<th>Summary of Challenges</th>
<th>4</th>
<th>3</th>
<th>2</th>
<th>1</th>
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<tr>
<td><em>summary_text</em></td>
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</tbody>
</table>

#### 8. Research for insights/solutions

<table>
<thead>
<tr>
<th>Summary of Opportunities</th>
<th>4</th>
<th>3</th>
<th>2</th>
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<tr>
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<tbody>
<tr>
<td><em>summary_text</em></td>
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</tbody>
</table>

### Part II. Capacity Assessment

<table>
<thead>
<tr>
<th>List emerging issues/policies in the public or private health care sectors that impact the local MCH program</th>
<th>Briefly describe MCH impact and response</th>
</tr>
</thead>
<tbody>
<tr>
<td>1.</td>
<td></td>
</tr>
<tr>
<td>2.</td>
<td></td>
</tr>
<tr>
<td>3.</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>List ongoing issues/policies in the public or private health care sectors that impact the local MCH program</th>
<th>Briefly describe MCH impact and response</th>
</tr>
</thead>
<tbody>
<tr>
<td>1.</td>
<td></td>
</tr>
<tr>
<td>2.</td>
<td></td>
</tr>
<tr>
<td>3.</td>
<td></td>
</tr>
<tr>
<td>List Collaboratives / Networks that MCH convenes</td>
<td>For its major planning body or bodies, provide a full description of membership or include roster/representation in an appendix. For others, summarize membership categories, e.g., child advocates, social services representatives, etc.</td>
</tr>
<tr>
<td>-------------------------------------------------</td>
<td>-------------------------------------------------------------------------------------------------------------</td>
</tr>
<tr>
<td>1.</td>
<td></td>
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<tr>
<td>2.</td>
<td></td>
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<tr>
<td>3.</td>
<td></td>
</tr>
<tr>
<td>4.</td>
<td></td>
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<tr>
<td>5.</td>
<td></td>
</tr>
<tr>
<td>6.</td>
<td></td>
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</tbody>
</table>

<table>
<thead>
<tr>
<th>List Collaboratives / Networks in which MCH participates as a member.</th>
<th>Summarize membership (see above)</th>
</tr>
</thead>
<tbody>
<tr>
<td>1.</td>
<td></td>
</tr>
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<td>2.</td>
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<td>3.</td>
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<tr>
<td>4.</td>
<td></td>
</tr>
<tr>
<td>5.</td>
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</tr>
</tbody>
</table>

(If applies) Briefly highlight any research activities MCH is involved in and how the findings have been used to increase MCH capacity or affect policies.

1.                                                                 |
| 2.                                                                 |
### MCH Program Capacity Assessment Worksheet

For internal use as needed / Not to be included in Assessment Report

<table>
<thead>
<tr>
<th>Area or Core Function:</th>
</tr>
</thead>
<tbody>
<tr>
<td><em>(List programs or activities if doing this as a group)</em></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Strengths:</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>Weaknesses:</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>Challenges:</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>Opportunities:</th>
</tr>
</thead>
</table>
COMMUNITY ASSESSMENT 1: BASIC CONCEPTS

Session Three
Measuring and Assessing Required Title V Indicators

Presented by:

Brianna Gass, MPH
MCH Project Coordinator
Family Health Outcomes Project
LEARNING OBJECTIVES

By the end of the presentation and session, participants will be able to collect and evaluate indicator data. Sub-objectives include:

1. Identify data resources and use to accurately calculate values for required indicators
2. Use FHOP data templates and other resources to evaluate indicator data
3. Identify problem areas based on the evaluation of selected indicators
4. Understand when and how to select additional indicators of local interest

REFERENCES FOR THIS SESSION

2. FHOP Website www.ucsf.edu/fhop under California MCH Data
3. Data sources for Indicators
4. FHOP Data Templates and Instructions
5. FHOP Tool for Summarizing Title V Indicators

OTHER MATERIALS FOR THIS SESSION

1. FHOP Perinatal Spreadsheet for county and CA state
2. Data tables for selected indicators
3. Data template for selected indicators
4. County profile for prenatal section (UC Berkeley)
5. County background summary
EXERCISE

Scenario:

You are part of an MCH staff group assigned to collecting and analyzing the required indicators for the Title V Needs Assessment process. You are asked to review the indicators selected and to present your conclusions based upon the data available. You have also been asked to discuss the next steps for data collection and problem analysis based on your findings.

For each of the following health indicators:

1. Examine the data provided
2. Discuss with the group what the data is showing in general
3. Discuss with the group how the county is doing compared to the state, applicable Healthy People 2010 Objectives, and other counties in California
4. Based on what is discussed, which indicators seem to pose the biggest problem for the county and why?
5. What other information might be useful in further evaluating each of the above indicators?

Prepare a brief summary of your findings and present to the larger group your rationale for identifying the indicators that pose a problem for your county, and the next steps in the process of analyzing the Title V Indicators.

Indicators being assessed in this exercise:

1. Number of teen births by age group
2. First trimester entry into prenatal care
3. Number of preterm births
4. Percent of children in poverty
Measuring and Assessing Required Title V Indicators

Brianna Gass, MPH
Family Health Outcomes Project
October 8, 2003

Objectives for this Session

- Define the required indicators for your Title V Assessments
- Identify resources for locating data for Title V Indicators
- Understand how to evaluate the data for each indicator
- Effectively use FHOP data templates and indicator rating tools

MCH Indicators

- Provide baseline data
- Uniformly defined for comparability
- Allow for problem identification
- Allow for tracking of changes over time
- Function as a performance measure
Background of Required Indicators

- What drove the CA MCH selection and decision process?
- Why were these indicators chosen and others eliminated?
- How does this set of indicators support the Title V Assessment process?

Title V Required Indicators: Selection Process

- Federal Title V Requirement
- MCH Directors survey identified priorities
- Availability of county-level data source
- State MCH program staff additions

What can CA MCH learn from the Indicator Assessment?

- Summary of county performances on each indicator
- How many counties’ values are significantly better or worse than the State?
- Which indicators were identified as priorities in which counties?
- Which indicators pose the most widespread problem?
27 Required Indicators!

- Data Resources on the Web
- Vital records
- Survey data
- Other community and government agencies

FHOP Resources

- Web site: www.ucsf.edu/fhop
- County-level tables and spreadsheets for indicators
- Data Templates
- Data evaluation tools
- Epi BC
- Technical Assistance

Data Sources on the Web

FHOP Website: www.ucsf.edu/fhop
- Data tables and spreadsheets
- Links to other sites with relevant data

Other websites (refer to handout)
- CA DHS Center for Health Statistics
- UC Berkeley MCH project
- UCLA/California Health Interview Survey
- CA EPIC Center- Injury Data
Now that you have data for each of the indicators....

What does it all mean?

Evaluating Indicator Data

- California State
- Other counties
- Healthy People 2010 Objectives
- Other areas of your Needs Assessment (e.g. Community Health Profile)
- Government surveys and reports
- MCH Literature

FHOP Data Templates

- Allow you to enter county data into pre-designed spreadsheet
- Display the comparison between your county data, the State and Healthy People 2010 Objectives
- May indicate a basic trend in your county, if one exists— “are things getting better or worse?”
### FHOP Data Templates exist for these indicators:

- Fertility rates/number of births
- Number of teen births by age group
- Number and percent low birth weight
- Number and percent very low birth weight
- Number and percent prenatal care in first trimester
- Number and proportion of women with adequate prenatal care
- Neonatal deaths and death rate for <28 days
- Post-neonatal deaths 28 days to a year
- Infant deaths and death rate birth to one year
- Percent of women exclusively breastfeeding at discharge
- Blank Template for rates and percentages

### FHOP Tool for Summarizing Indicators

- Allow counties to see their assessments of required indicators in summary form:
  - List values for each indicators
  - Show comparison to State and Healthy People Objectives
  - Specify priority indicators
  - Explain how conclusions were drawn
- Allows for comparability across counties

### GROUP EXERCISE

Measuring and Assessing Required Indicators
Identifying and Selecting Additional Maternal Child Health Indicators

Judith A. Hager Belfiori, MA, MPH
Family Health Outcomes Project
October 8, 2003

Where does this process fit into the overall assessment process?

MCH Mission Statement & Goals

Community Assessment
Community health profile
Assess community resources
Assess MCH program capacity
Assess State required MCH indicators
Select / assess locally determined MCH indicators
Identification of Problems/Unmet needs
Select priority MCH problems/needs in the jurisdiction
Preliminary problem analysis for priority problems

Why / When is it necessary?

If required indicators do not include the indicators of local interest (e.g., perinatal substance use, risky teen behaviors)
Setting the Stage to Identify and Select among additional (locally determined) MCH Indicators

- Use planning group (inclusive)
- Review mission and overall goals
- Use the process appropriate to your needs

Selecting Additional Indicators

• For some, no problem

For others, not an easy process

Process of Selecting Additional Indicators

- Review required indicators and discuss other assessment needs
- Agree on selection method and whether there is a need for a process
- Brainstorm / review list of additional indicators
- Agree on indicators to be used. If a process is needed, refer to FHOP Planning Guide
Identify Additional Indicators

Group identifies indicators under each MCH goal. These are in addition to--do not replace the required indicators.

Example
Goal 1. All pregnant women give birth to a healthy child
- % of women who smoke during pregnancy
- % of women with an identified substance abuse problem at delivery of their baby
- % of women with gestational diabetes

Talk About:
Criteria for selection

Example Criteria
The indicator is:
- quantifiable
- Data is easily available (e.g., FHOP website)
- Reflects high impact on local MCH population

Construction of Indicator

Staff work:
- Develop precise definition
- Define numerator and denominator
- Identify data sources
- Identify a standard for comparison or a comparison group or time period
Agree on Indicators to be used

- If a formal process is needed, refer to FHOP Planning Guide / TA
- Confirm the results of the informal / formal process with the group
- Document the results
<table>
<thead>
<tr>
<th></th>
<th>Definition</th>
<th>Numerator Denominator</th>
<th>Data Source</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Number of births &amp; fertility rates</td>
<td>Number of live births &amp; Total population</td>
<td><a href="http://www.ucsf.edu/fhop/dataport/perinatal/">http://www.ucsf.edu/fhop/dataport/perinatal/</a> (FHOP will update with latest data when available)</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td><a href="http://datamch.berkeley.edu/ccpr.html">http://datamch.berkeley.edu/ccpr.html</a> (also includes trend tables and data maps)</td>
</tr>
<tr>
<td>2</td>
<td>Number and teen birth rate per 1000 females</td>
<td>Number of births among age group &amp; Total population in age group</td>
<td><a href="http://www.ucsf.edu/fhop/dataport/perinatal/">http://www.ucsf.edu/fhop/dataport/perinatal/</a> (FHOP will update with latest data when available)</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td><a href="http://datamch.berkeley.edu/ccpr.html">http://datamch.berkeley.edu/ccpr.html</a> (by age; also includes trend tables and data maps)</td>
</tr>
<tr>
<td>3</td>
<td>Number and percent low birth weight (live births)</td>
<td>Number of live infants born weighing less than 2500 grams &amp; Total number of live births</td>
<td><a href="http://www.ucsf.edu/fhop/dataport/perinatal/">http://www.ucsf.edu/fhop/dataport/perinatal/</a> (FHOP will update with latest data when available)</td>
</tr>
<tr>
<td></td>
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<td></td>
<td><a href="http://datamch.berkeley.edu/ccpr.html#select">http://datamch.berkeley.edu/ccpr.html</a> (also includes trend tables and data maps)</td>
</tr>
<tr>
<td>4</td>
<td>Number and percent very low birth weight (live births)</td>
<td>Number of live infants born weighing less than 1500 grams &amp; Total number of live births</td>
<td><a href="http://www.ucsf.edu/fhop/dataport/perinatal/">http://www.ucsf.edu/fhop/dataport/perinatal/</a> (FHOP will update with latest data when available)</td>
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<td></td>
<td><a href="http://datamch.berkeley.edu/ccpr.html#select">http://datamch.berkeley.edu/ccpr.html</a> (also includes trend tables and data maps)</td>
</tr>
<tr>
<td>5</td>
<td>Number and percent preterm births (less than 37 weeks gestation)</td>
<td>Number of live births occurring before 37 weeks &amp; Total number of live births</td>
<td><a href="http://www.dhs.ca.gov/hisp/chs/OHIR/vssdata/2002data/02Ch2Ex/2_24_2002c.xls">http://www.dhs.ca.gov/hisp/chs/OHIR/vssdata/2002data/02Ch2Ex/2_24_2002c.xls</a></td>
</tr>
<tr>
<td>6</td>
<td>Number and percent of births occurring within 24 months of a previous birth</td>
<td>Number of births occurring within 24 months of previous birth &amp; Total number of births occurring within 24 months of previous birth</td>
<td><a href="http://datamch.berkeley.edu/ccpr.html#select">http://datamch.berkeley.edu/ccpr.html</a> (within 23 months of previous birth; also includes trend tables and data maps) FHOP is also preparing age specific data for this indicator and will post to website.</td>
</tr>
<tr>
<td>Number</td>
<td>Description</td>
<td>Formula</td>
<td>FHOP Notes</td>
</tr>
<tr>
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</tr>
<tr>
<td>7</td>
<td>Number and percent of teen births to women who were already mothers</td>
<td>Number of repeat teen births / Total number of teen births</td>
<td>FHOP is preparing data for this indicator and will post to website.</td>
</tr>
<tr>
<td>8</td>
<td>Perinatal death rate</td>
<td>Number of fetal deaths after 20 weeks gestation / Total live births + number of fetal deaths</td>
<td><a href="http://datamch.berkeley.edu/ccpr.html">http://datamch.berkeley.edu/ccpr.html</a> (also includes trend tables and data maps) Links to excel tables are on FHOP website under CA MCH data</td>
</tr>
<tr>
<td>9</td>
<td>Neonatal deaths and death rate (birth - &lt;28 days)</td>
<td>Number of infant deaths 0-28 days / Total number of live births</td>
<td><a href="http://www.ucsf.edu/fhop/dataport/perinatal/">http://www.ucsf.edu/fhop/dataport/perinatal/</a> (FHOP will update with latest data when available) <a href="http://datamch.berkeley.edu/ccpr.html">http://datamch.berkeley.edu/ccpr.html</a> (also includes trend tables and data maps)</td>
</tr>
<tr>
<td>10</td>
<td>Post-neonatal deaths and death rate (&gt;28 days – 1 year)</td>
<td>Number of infant deaths 28 days-1 year / Total number of live births</td>
<td><a href="http://datamch.berkeley.edu/ccpr.html">http://datamch.berkeley.edu/ccpr.html</a> (also includes trend tables and data maps) Links to excel tables are on FHOP website under CA MCH data</td>
</tr>
<tr>
<td>11</td>
<td>Infant deaths and death rate (birth – 1 year)</td>
<td>Number of infant deaths birth-1 yr / Total number of live births</td>
<td><a href="http://www.ucsf.edu/fhop/dataport/perinatal/">http://www.ucsf.edu/fhop/dataport/perinatal/</a> (FHOP will update with latest data when available) <a href="http://datamch.berkeley.edu/ccpr.html">http://datamch.berkeley.edu/ccpr.html</a> (also includes trend tables and data maps)</td>
</tr>
<tr>
<td>12</td>
<td>Deaths and death rate per 100000 age 1-14 and age 15-19</td>
<td>Number of deaths in age group / Total population in age group</td>
<td>FHOP is preparing these data and will post to website when available</td>
</tr>
<tr>
<td>13</td>
<td>Number and percent prenatal</td>
<td>Number of births to women who</td>
<td><a href="http://www.ucsf.edu/fhop/dataport/perinatal/">http://www.ucsf.edu/fhop/dataport/perinatal/</a> (FHOP will update with latest data when available)</td>
</tr>
<tr>
<td>Indicator</td>
<td>Description</td>
<td>Source</td>
<td>Notes</td>
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<td>--------------------------------------------------------------------------</td>
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</tr>
<tr>
<td>care in first trimester (live births)</td>
<td>received prenatal care during the first trimester</td>
<td><strong>Total number of live births</strong></td>
<td><strong>Number of women who received adequate prenatal care (Kotelchuck index)</strong></td>
</tr>
<tr>
<td>14 Number and proportion of women (age 15-44) with adequate prenatal care (Kotelchuck index)</td>
<td>Number of women who received adequate prenatal care</td>
<td><strong>Total number of live births</strong></td>
<td><a href="http://datamch.berkeley.edu/ccpr.html">www.datamch.berkeley.edu/ccpr.html</a> (also includes trend tables and data maps)</td>
</tr>
<tr>
<td>15 Percent of women who were breastfeeding at the time of hospital discharge</td>
<td>Number of women who breastfeed at time of discharge</td>
<td><strong>Total number of postpartum women</strong></td>
<td>MCH Epidemiology section is preparing these data and will post to website when available</td>
</tr>
<tr>
<td>16 Percent of children and adolescents without health insurance</td>
<td>Number without health insurance</td>
<td><strong>Total number of children and adolescents</strong></td>
<td><a href="http://www.chis.ucla.edu/">www.chis.ucla.edu/</a> (requires registration- username and password)</td>
</tr>
<tr>
<td>17 Percent of children without dental insurance (age 2-11)</td>
<td>Number without dental insurance</td>
<td><strong>Total children aged 2-11</strong></td>
<td><a href="http://www.chis.ucla.edu/">www.chis.ucla.edu/</a> (requires registration- username and password)</td>
</tr>
<tr>
<td>18 Percent of children who have been to the dentist in the past year (age 2-11)</td>
<td>Number of children to dentist in year</td>
<td><strong>Total children aged 2-11</strong></td>
<td><a href="http://www.chis.ucla.edu/">www.chis.ucla.edu/</a> (requires registration- username and password)</td>
</tr>
<tr>
<td></td>
<td>Description</td>
<td>Data Source</td>
<td>Notes</td>
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</tr>
<tr>
<td>20</td>
<td>Rate of children hospitalized for asthma per 10000 (age 0-4 and age 5-18)</td>
<td>Number of hospitalizations / Number of children in age group</td>
<td><a href="http://www.ucsf.edu/fhop/">www.ucsf.edu/fhop/</a> (click on CA MCH data and go down to asthma) FHOP will be posting trend data to website</td>
</tr>
<tr>
<td>21</td>
<td>Rate per 1000 women aged 15-19 with a reported case of chlamydia</td>
<td>Number of cases among women in age group / Number of women in age group</td>
<td>Links to tables are on FHOP website under CA MCH data The STD Branch is preparing tables with Confidence Intervals.</td>
</tr>
<tr>
<td>22</td>
<td>Rate of children hospitalized for mental health reason per 10000 (age 5-14, age 15-19)</td>
<td>Number of hospitalizations in age group / Total number in age group</td>
<td>FHOP is preparing these data and will post to website when available</td>
</tr>
<tr>
<td>23</td>
<td>Number and rate of hospitalizations for all non-fatal injuries by age group 0-14, 15-24</td>
<td>Number of hospitalizations in age group / Total number in age group</td>
<td>FHOP is preparing these data and will post to website when available</td>
</tr>
<tr>
<td>24</td>
<td>Rate of non-fatal injuries due to motor vehicle accidents (age 0-14, 15-24)</td>
<td>Number of injuries in age group / Total number in age group</td>
<td><a href="http://www.applications.dhs.ca.gov/epicdata/content/sum_causebyage.htm">http://www.applications.dhs.ca.gov/epicdata/content/sum_causebyage.htm</a> FHOP is preparing these data and will post to website when available</td>
</tr>
<tr>
<td>25</td>
<td>Number of children living in foster care for selected month (July)</td>
<td><a href="http://cssr.berkeley.edu/CWSCMSreports/pointintime/fostercare/childwel/prevalence.asp">http://cssr.berkeley.edu/CWSCMSreports/pointintime/fostercare/childwel/prevalence.asp</a>. Links to tables are on FHOP website under CA MCH data</td>
<td></td>
</tr>
<tr>
<td>26</td>
<td>Percent of children in poverty, aged 0-19</td>
<td>Number below poverty level, Number of children in age group. Links to tables are on FHOP website under CA MCH data</td>
<td></td>
</tr>
<tr>
<td>27</td>
<td>Percent of women ages 18 or older reporting intimate partner physical abuse in last 12 months</td>
<td><a href="http://justice.hdcdojnet.state.ca.us/cjsc_stats/prof99/index.htm">http://justice.hdcdojnet.state.ca.us/cjsc_stats/prof99/index.htm</a>, <a href="http://justice.hdcdojnet.state.ca.us/cjsc_stats/prof00/index.htm">http://justice.hdcdojnet.state.ca.us/cjsc_stats/prof00/index.htm</a>, <a href="http://justice.hdcdojnet.state.ca.us/cjsc_stats/prof01/index.htm">http://justice.hdcdojnet.state.ca.us/cjsc_stats/prof01/index.htm</a>. FHOP is also preparing these data and will post to website when available</td>
<td></td>
</tr>
</tbody>
</table>
COMMUNITY ASSESSMENT 1: BASIC CONCEPTS

Session Four

Options for Collecting and Presenting Assessment Data

Presented by:

Geraldine Oliva, MD, MPH
Director
Family Health Outcomes Project
LEARNING OBJECTIVES:

By the end of the presentation and session, participants will be able to:

1. Give at least two examples of the advantages and disadvantages of using quantitative vs. qualitative data
2. Identify at least three criteria for evaluating a quantitative data source
3. Select an appropriate data source for two sample indicators
4. Determine the most effective way to present data on a sample indicator

REFERENCES FOR THIS SESSION

Options for Collecting and Presenting Assessment Data

Geraldine Oliva, M.D. MPH
Family Health Outcomes Project
October 8, 2003

Session Objectives
By the end of this session participants will be able to:

- Give at least two examples of the advantages and disadvantages of using quantitative data vs. qualitative data
- Identify at least three criteria for evaluating a quantitative data source
- Select an appropriate data source for two sample indicators
- Determine the most effective way to present data on a sample indicator
Choosing a Data Source

- Quantitative Data – numbers, rates, statistics
  - Primary - you collect it
  - Secondary – use an existing data source

- Qualitative Data – words, thoughts, actions, intentions

Quantitative Data: Advantages

- Quantifies results
- Allows statistical comparisons and multivariate analyses
- Allows comparisons with other groups and over time using standard measures
- Conserves resources if secondary data source available

Quantitative Data: Disadvantages

- Requires expertise in data analysis
- Limited use in situations where numbers are small
- Collecting primary data is expensive and time-consuming
- Can overlook emerging issues
Quantitative Data: Disadvantages
- Presupposes you to know the significant factors
- Often lacks important variables such as geographic markers or detailed race or ethnicity categories
- May not be timely

Qualitative Data: Advantages
- Rich data with more details and contextual information
- Can provide new insights
- Can identify emerging issues
- Face-to-face contact allows opportunity to clarify questions
- Can be timely and current

Qualitative Data: Disadvantages
- Requires expertise in staff and can be time consuming
- Possible inconsistency due to flexibility
- Difficult to make comparisons
- Transcribing and reduction of data costly
- Individuals may alter responses because of group environment
Factors to Consider in Choosing the Type of Data You Need

- Is this a well described and quantifiable problem?
- Do I want to compare data with known standards or other population groups?
- Do I have an evidenced based hypothesis about the cause of a problem or am I searching for new insights?

Factors to Consider in Choosing the Type of Data You Need (cont)

- Do I want to understand the perspective of the community?
- Will quantitative data be meaningful? (i.e. adequate numbers)
- Are there reliable secondary data sources available?
- Are there adequate local resources for a particular method?

Criteria for Assessing a Secondary Data Source

- Accuracy and Consistency
- Adequate sample size for local community
- Contains the specificity for local needs
- Timeliness
- Cost
- Availability over time
Considerations for Primary Data Collection

- Existence of a validated instrument or set of questions for area(s) of interest
- Potential sample size
- Potential for random sample
- Resource availability - $ and expertise

Choosing a Qualitative Method

- Determining the objectives for the study and identifying the type of information needed
- Identifying local expertise in both conducting the data collection and analyzing the data collected
- Identifying resources
Mini-Exercise: What is the Best Data Source for These Indicators?

- Infant mortality rate
- Barriers to early entry into prenatal care
- Use of infant car seats
- Prevalence of childhood obesity

Analyzing the Data

- Answer the who, what, where, when and why of epidemiology
- Describe the population affected (e.g. age, race/ethnicity, place of residence, income)
- Include at least 5 years to observe direction
- Compare to a standard such as HP 2010
- Make statistical comparisons where possible
Addressing Methodological Issues

- Fewer than 10 cases over 3 years
- Only one year of data
- Unclear meaning of indicator
- Multiple indicator definitions
- Finding a denominator

Addressing Methodological Issues: Examples

- Infant mortality cases: 7 for 1999-2001
- Percent Uninsured from CHIS survey
- Rate per 1000 of children living in foster care
- Percent of teens 15-19 using alcohol
- Rate of mental health admissions by payor source

Presenting the Data

- Identify key findings
- Select a graphic to convey your message
- Always show numbers as well as rates
- Indicate data source
- Note statistical significance
- Provide concise interpretations
- Discuss any lack of data
Infant Mortality Rates, Alameda County 1992-2000

Infant Mortality Rate, Alameda County 1997-1999

Percent of Infant Deaths by Race/Ethnicity, Alameda County 1995-1997 (N=382)
Percent of Low Birthweight Babies by Race/Ethnicity, Alameda County 1998

- White: 32%
- Black: 28%
- Hispanic: 22%
- Asian: 18%
- AmIndian: 0%

Percent of Babies Low Birth Weight by Race/Ethnicity, Alameda County 1998

- White: 6.1%
- African American: 17.6%
- Hispanic: 5.9%
- Asian/Pacific Islander: 5.8%

Teen Birth Rate (10-19yrs), Alameda County 1992-2000

- County Point Estimate
- State Point Estimate

FHOP Community Assessment 1  October 2003
Take Home Points

- Collect data that is meaningful for your jurisdiction
- Use quantitative data and qualitative data where feasible to tell your story
- Display data in a way that emphasizes the most important findings

RELAX !!!